The impact of mental illness on older adults is considerable. Prevalence in this population of mental disorders of all types is substantial. Eight to 20 percent of older adults in the community and up to 37 percent in primary care settings experience symptoms of depression, while as many as one in two new residents of nursing facilities are at risk of depression. Older people have the highest rate of suicide in the country, and the risk of suicide increases with age. Americans age 85 years and up have a suicide rate of 65 per 100,000. Older white males, for example, are six times more likely to commit suicide than the rest of the population. There is a clear correlation of major depression and suicide: 60 to 75 percent of suicides of patients 75 and older have diagnosable depression. Put another way, untreated depression among the elderly substantially increases the risk of death by suicide.

Mental disorders of the aging are not, of course, limited to major depression with risk of suicide. The elderly suffer from a wide range of disorders including declines in cognitive functioning, Alzheimer's disease (affecting 8 to 15 percent of those over 65) and other dementias, anxiety disorders (affecting 11.4 percent of adults over 55), schizophrenia, bipolar disorder, and alcohol and substance use disorders. Some 3 to 9 percent of older adults can be characterized as heavy drinkers (12 to 21 drinks per week). While illicit drug use among this population is relatively low, there is substantial increased risk of improper use of prescription medication and side effects from polypharmacy.

While we tend to think of Medicare as a ''senior citizen's health insurance program,'' there are substantial numbers of disabled individuals who qualify for Medicare by virtue of their long-term disability. Of those, the National Alliance for the Mentally Ill reports that some 400,000 non-elderly disabled Medicare beneficiaries become eligible by virtue of mental disorders. These are typically individuals with the severe and persistent mental issnesses, such as schizophrenia.

Regardless of the age of the patient and the specific mental disorder diagnosed, it is absolutely clear that mental illness in the Medicare population causes substantial hardships, both economically and in terms of the consequences of the illness itself. As Dr. Satcher puts it, ''mental illnesses exact a staggering toll on millions of individuals, as well as on their families and communities and our Nation as a whole.''

Yet there is abundant good news in our ability to effectively and accurately diagnose and treat mental illnesses. The majority of people with mental illness can return to productive lives if their mental illness is treated. That is the good news: Mental illness treatment works. Unfortunately, today, a majority of those who need treatment for mental illness do not seek it. Much of this is due to stigma, rooted in fear and ignorance, and an outmoded view that mental illnesses are character flaws, or a sign of individual weakness, or the result of indulgent parenting. This is most emphatically not true. Left untreated, mental illnesses are as real and as substantial in their impact as any other illnesses we can now identify and treat.

Mr. Speaker, Medicare's elderly and disabled mentally ill population faces a double burden. Not only must they overcome stigma against their illness, but once they seek treatment the Federal Government via the Medicare program forces them to pay half the cost of their care out of their own pockets. Congress would be outraged and rightly so if we compelled a Medicare cancer patient to pay half the cost of his or her outpatient treatment, or a diabetic 50 cents of every dollar charged by his or her endocrinologist. So why is it reasonable to tell the 75-year-old that she must pay half the cost of treatment for major depression? Why should the chronic schizophrenic incur a 20 percent copayment for visiting his internist, but be forced to pay a 50 percent copayment for visiting a psychiatrist for the treatment of his schizophrenia?

It is most emphatically not reasonable. It is blatant discrimination, plain and simple, and we should not tolerate it any longer. That is why I am introducing the Medicare Mental Illness Non-Discrimination Act. It is time we acknowledged what Dr. Satcher and millions of patients and physicians and other health professionals and researchers have been telling us: Mental illnesses are real, they can be accurately diagnosed, and they can be just as effectively treated as any other illnesses affecting the Medicare population. We can best do that by eliminating the statutory 50 percent copayment discrimination against Medicare beneficiaries who, through no fault of their own, suffer from mental illness.

My legislation is extremely simple. It repeals Section 1833(c) of the Social Security Act, thereby eliminating the discriminatory 50 percent copayment requirement. Once enacted, patients seeking outpatient treatment for mental illness would pay the same 20 percent copayment we require of Medicare patients seeking treatment for any other illnesses. My bill is a straightforward solution to this last bastion of Federal health care discrimination.

Last year, via Executive Order we at last initiated parity coverage of treatment for mental illness for our federal employees and their families. Members of Congress and their staff, who are covered under FEHPB, have parity for treatment of mental illnesses. If parity is good enough for federal employees and for Members of Congress and their staff, can we now do any less for our Medicare beneficiaries? I urge my colleagues to join with me in righting this wrong.

Mr. Speaker, I ask that a letter in support of this legislation from Dr. Daniel B. Borenstein, President of the American Psychiatric Assocaiton, be included in the Record.

AMERICAN PSYCHIATRIC ASSOCIATION,
Washington, DC, January 5, 2001.

Hon. MARGE ROUKEMA,
House of Representatives, Rayburn House Office Building, Washington DC.

DEAR CONGRESSWOMAN ROUKEMA: The American Psychiatric Association (APA) a medical specialty society representing over 40,000 psychiatric physician nationwide, is deeply concerned about the crisis surrounding children's mental health. We welcome the opportunity to work with the 107th Congress as it presents America with the opportunity to dedicate itself to the well being of our children and families.

According to the ''National Action Agenda on Children's Mental Health'' released by the Surgeon General earlier this week; the United States is facing a disastrous state of health care for children. In the U.S., 1 in 10 children and adolescents suffer from mental illness severe enough to cause impairment. Yet, in any given year, it is estimated that fewer than 1 in 5 of these children receives needed treatment. The long-term consequences of untreated childhood disorders are costly, both in human and fiscal terms.

It is a national crisis that millions of Americans continue to struggle with mental illness. Children and families are suffering because of missed opportunities for prevention and early identification, low priorities for research and resources and fragmented services. Overriding all of this is the issue of stigma, which continues to surround mental illness.

The American Psychiatric Association and our members are pleased to offer our medical expertise and experience expertise to you and your staff on the critical issues outlined in the Surgeon General's Report. We place particular emphasis on the Report's call for the need to: develop and disseminate scientifically-proven prevention, diagnostic and treatment services in the field of children's mental health; eliminating the ethnic and socioeconomic disparities in access to mental health care; and increasing access to and coordination of quality mental health care services. If the APA can be of further assistance, have your staff contact our Division of Government Relations at 202/682–6060.

Sincerely,
DANIEL B. BORENSTEIN, M.D.,
President.

HONORING MARY VIRGINIA BURRUS

HON. JAMES A. LEACH

OF IOWA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, February 13, 2001

Mr. LEACH. Mr. Speaker, today I express my gratitude and appreciation for the work of Mary Virginia ''Ginny'' Burrus.

Ginny joined my staff on January 16, 1985, providing constituent service in my Burlington, Iowa, office. She and her late husband David owned their own business in Burlington and she had long been active in promoting tourism, the arts as well as the economy of southeastern Iowa.

After redistricting, Ginny helped open my Iowa City office in 1992, continuing to provide outstanding service to the residents of Iowa's First Congressional District.

All of my colleagues know how essential to the functioning of government is the ombudsman role in Congressional offices, and particularly caseworkers within them, play. For constituents with problems, be it with veterans benefits, Social Security, Medicare or student loans, the federal bureaucracy can be a bewildering maze, the applicable laws and regulations often seemingly irrational. An experienced, knowledgeable and sympathetic caseworker can be indispensable in getting the answers needed and problems resolved.

In the 16 years she worked with me, Ginny epitomized the consummate professional and her file is fat with letters from Iowans thanking her for the help she provided. In recent years, as immigration casework increased, her knowledge of immigration law, regulations, processes and paperwork has become legendary. Equally well known has been her patience, both with harried staffers at INS and with newcomers to this country, unfamiliar with both its language and its ways.

Ginny has provided me and the citizens of Iowa a model of what public service is all about. She will now have more time to enjoy